STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 01 B. WING	03/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/04/13 Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, University Park Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	resident rooms. The facility has a capacity of 104 and had a census of 72 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a garage providing facility services including the storage of maintenance supplies that was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/11/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on an observation with the Maintenance Supervisor on 03/04/13 at 1:24 p.m., there was a four inch round hole in the ceiling above the ceiling light fixture in the Housekeeping office. The Maintenance Supervisor acknowledged the hole in the ceiling and provided the measurements at the time of observation. 3.1-19(b)	K010025	It is the practice of this facility that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3I No residents were affected.II. Residents did not have the potential to be affected, the area was not in residential care area.III. The ceiling light fixture was repaired by maintenance director, it was then sealed with and caulked with fire rated caulk.IV.All offices were inspected for similar areas, none were found. (see attachment# 1) V. Completed 3/8/13	04/03/2013

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K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 6 exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect any resident evacuated through the service hall in the event of an emergency. Findings include: Based on observations with the Maintenance Supervisor on 03/04/13 at 1:45 p.m., the exit door in the service hall was equipped with electromagnetic locks that released after pushing the door for 15 seconds but it lacked signage regarding pushing the door to open. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-15(b)	K010038	It is the practice of this facility that all exit doors have readable signage for directions.I. No residents were affected.II. Some residents who could potentially be in the local area in the event of an energency would have the potential to be affected.III. The signs have been purchased and posted at the service hall door. (see attachment #2) Staff have been inserviced on the posting and use of the sign. (see attachment2a) sig: sheet.IV. The maintenance director will check all other egress doors and ensure that the signs are visible. The maintenance director will audit the signs monthly to ensure they are on and visible. The maintenance director will bring the audits to the monthly QMP meeting for compliance commitee review, for 6 months.V. 4/3/13	04/03/2013

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K010048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan which included the response to the resident room battery operated smoke detectors in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Supervisor on 03/04/13 at 12:00 p.m., the "Disaster Plan" did not include the policy and procedure for staff in the event a battery operated smoke detector in the resident room goes into alarm. Based on interview with the	K010048	It is the policy of this facility, that the facility include in the Disaster Manual a written plan for the response to the Battery operated Smoke Dectors when activated. I. No residents were affected.II. All residents could have the potential to be affected.III. A written procedure for response if the battery operated smoke dector goes into alarm, is now included in the facility disaster manual.(see attachment# 3).B. A inservice for staff will be done on 3/21/13 on all shifts to educate and inform the staff of the written procedure and its content and location.(see attachment 3a)IV. The maintenance director will do random audits of staff during each fire drill performed monthly to ensure that staff is aware of the procedure.This monthly audit tool will be brought to the monthly QMP meetings for review by the committee to ensure compliance for 6 mos.(see attachment # 3 b) V. Completion: 4/3/13	04/03/2013

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	Maintenance Supervisor at the time of record review, no other documentation was available for review. 3.1-19(b)			

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K010052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect an unknown number of residents since the exact location of the missed smoke detector could not be determined. Findings include: Based on review of FairChild smoke detector record titled "Detector Sensitivity Test Report" dated 03/11/11 with the Maintenance Supervisor on 03/04/13 at 11:44 a.m., only forty of the forty one smoke detectors in the facility received a smoke detector sensitivity test. Based on	K010052	It is the policy of this facility that the fire alarm systems are maintained in accordance with the requirements of NFPA 72.I. No residents were affected.II. Some residents could have the potential to be affected if in the area of the service hall, they typically do not frequent this area. III. ASG/company has done the annual sensitivity tests for all smoke dectors. (see attachment #4) All are working properly.IV.The maintenance director will ensure that the Smoke Dector #41 will be included on the annual paperwork from ASG (see attachment #4).The maintenance director will review the annual test results with the ED and ASG to ensure a through inspection of all dectors has been done at the time of exit with the ASG/company.V. Completion: 3/7/13	04/03/2013

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	an interview with the Maintenance Supervisor at the time of record review, he was unable to provide documentation to confirm the one smoke detector had receive a smoke detector sensitivity test. 3.1-19(b)			

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K010056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 3 of 4 building overhangs in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect all residents in the event of an emergency. Findings include: Based on an observations with the Maintenance Supervisor on 03/04/13 from 12:39 p.m. to 1:19 p.m., at each of the 100, 200, and 300 hall exits there is a	K010056	It is the practice of this facility, that the sprinkler system for this facility will provide complete coverage for the building if so needed. I. No negative outcomes, no residents were affected.II. All residents could have the potential to be affected.III. Shambaugh & Sons has installed sprinkler systems to the 3 overhangs or canopies. (See attachment #5) for completed work verification.IV. The additions to the sprinkler system will be checked and documentated annually on the electronic TELS system and through the vendor paperwork, when the annual service is performed, for record.V. Completed: 3/27/13	04/03/2013

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	combustible overhang extending fifty two inches from the building. Measurements were provided by the Maintenance Supervisor at the time of observations. 3.1-19(b)			

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K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 3 fire extinguishers in the 300 hall each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious physical damage or condition to prevent its operation. This deficient practice could affect any of the 20 residents in the 300 hall. Findings include: Based on observations with Maintenance Supervisor on 03/04/13 at 1:10 p.m., the monthly inspection tag for the fire extinguisher near the exit door on the 300 hall lacked documentation of a monthly inspection and an annual inspection for	K010064	It is the practice of this facility to inspect the fire extinguishers on the Halls thru out the facility, monthly.and document checks on the tags on the fire extinguishers.I. No residents were affected.II. The 20 residents on the 300 hall could have the potential to be affected.III.The Maintenance director will do weekly checks on the 300 hall to ensure that tags are on the fire extinguishers, according to NFPA 10. (See attachment # 6 &6a)IV. The maintenance director will bring the documented audits of 300 hall fire extinguisher checks to the monthly QMP meetings for review by the committee, for 6 months.V. Completed 3/20/13	04/03/2013

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	the previous year. Additionally, the pin had been removed. Based on an interview with the Maintenance Supervisor at the time of observation, this was the facilities locked unit and he had a problem with residents removing the inspection tags. 3.1-19(b)			

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K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to provide 1 of 1 smoking areas with a self closing metal container which was used to empty ashtrays only. This deficient practice could affect at least 5 residents who currently smoke. Findings include: Based on an observation with the Maintenance Supervisor on 03/04/13 at 1:35 p.m., the covered hard plastic trash can in the resident smoking area contained a mixture of cigarettes butts	K010066	It is the practice of this facility will provide self closing metal container to use for ashtrays only.I. No residents were affected.II. This could have the potential to affect the 5 residents who smoke.III. The facility has purchased a metal self closing ashtray, to provide the acceptable container as required. (See attachment#8) proof of purchase of self closing ashtray.IV. The Maintnenace director will ensure that the metal container is secured for residents to use, when needed.. Maintnenance director will audit the smoke area	04/03/2013

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	and combustible trash. Additionally, a metal trash can was not provided at the smoking area. The only trash can available was one made of hard plastic. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		to ensure that the metal container is present, weekly for 6 months, this audit tool will be brought to the monthly QMP meetings for review by the committee, to ensure compliance.V. Completion: 3/19/13	

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UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on observation and interview with the Maintenance Supervisor on 03/04/13 at 12:55 p.m., he acknowledged two refrigerators were supplied electricity by an extension cord power strip in the 200 hall medication room. 3.1-19(b)	K010147	It is the prctice of this facility to ensure that flexible cords are not used in the facility.I. No residents were affected.II. No residents would have had the potential to be affected.III. A fixed quad outlet was installed in the 200 hall med room. All med rooms were audited for power cords, (none found) by maintnenance director. (See attachment # 8) IV. The med rooms will be audited monthly by the maintenenance director.The audits will be brought to the QMP meetings monthly for 6 months, for review by the committee to ensure compliance,V. Completetion: 4/3/13	04/03/2013